Issue 16: January 2022

Newsletter

Working in partnership to enable adults in Somerset to live a life free from fear, harm or abuse

This is the 16th edition of the Somerset Safeguarding Adults Board (SSAB) newsletter, and we hope those who have received copies since its launch continue to find it a useful resource and an interesting read.

To the new subscribers who have recently signed up to receive copies of our newsletter, a very warm welcome and our thanks for your interest in being part of our local safeguarding community in Somerset.

We always welcome any suggestions for improvement, requests for future content or any contributions you'd like to make.

In this issue:

News from the SSAB

The Somerset Safeguarding Adults Board will next be meeting in February 2022. Since our previous newsletter, we have published one new Safeguarding Adults Review which you can read more about on page 9. The Board has also been busy analysing organisational self-audit returns.

As we prepare for a new financial year, we will be keen to invite your feedback on our next Strategic Plan and will soon be contacting all readers of this newsletter to enable you to offer your views and opinions on our draft proposal.

Guidance and leaflets

Since our last newsletter we have published an adapted version of the animation "Tricky Friends".

"Tricky Friends" is a short animation originally developed by our colleagues at the Norfolk Safeguarding Adults Board, that the Somerset Safeguarding Adults Board has been kindly allowed to adapt to include the contact details for Somerset Direct, to help people to understand what good friendships are, when they might be harmful, and what they can do.

It is important that people with learning disabilities and autism, those who have cognitive difficulties, and also children and young adults, have positive opportunities to make and maintain friendships.

We want to help them to do this while reducing the risk of harm and exploitation for those who may be less able to recognise the intentions of others.

We hope this animation is used as a way to help people to think about the issues, to start those conversations, and to help them to keep themselves safe while enjoying friendships.

It is only 3 minutes long and can be used with or by anyone – carers, family, organisations, groups.

We hope you find it helpful, and thank our colleagues at Somerset County Council for providing funding for the adaptions to be made.

Further information

- **Watch the animation**
- **SSAB Mate Crime Leaflet**

SSAB Self-Audit 2021

Thank you to everyone who submitted a self-audit ahead of the deadline in October.

Audits were completed by a total of seventeen organisations, which is a significant increase over previous years, and we have recently presented the draft analysis to the Board's Quality and Performance Subgroup. The next step will be to present the findings to the SSAB Board when it next meets in February, and we will be making contact with a small number of organisations that submitted a self-audit but are not Board members, to offer them the chance to receive the same presentation.

We have also met with colleagues within the region to identify common themes that we can take forward together, and a summary of these will be included in our 2021/22 Annual Report.

Going forwards, the SSAB Performance and Quality Assurance Subgroup has agreed that we will move to a biennial self-audit cycle, with the next scheduled for 2023.

Stop Adult Abuse Week Regional Webinar Series

We would like to extend a huge thank you to everyone who supported us and engaged with Stop Adult Abuse Week which took place during the 15th to 19th of November 2021.

It was great to see so many professionals across Somerset taking part, both in attending and promoting the webinar series, but also in sharing important safeguarding messages with their networks.

If you would like to see some of the key messages shared during that week, we would recommend taking a look at our **Twitter** page, but also the resources from the **Ann Craft Trust website**.

Further information

- **Slides from the SSAB's webinar on 'Promoting Safer Cultures' are available here**
- **Recordings of the webinars in the series**

Spot the Signs of Domestic Abuse and Modern Slavery

New free online resources are available for both professionals and the public to help spot the signs and reduce the risk of becoming a victim of domestic abuse and modern slavery. This new range of online learning modules will give professionals further confidence on next steps and the help and support they can provide to victims.

Members of the public also have free access to a set of modules providing guidance on recognising the signs of domestic abuse and modern slavery and what they can do to help, and we encourage all organisations to actively promote them.

Further information

- **e-Learning modules for the professionals**
- **e-Learning modules for the public**

Older and Safer, Without Abuse

Older people who are experiencing fear and harm from their partners, ex-partners, or family members are encouraged to seek help and support in a new Safer Somerset Partnership campaign launched in December 2021.

- The **Older people and domestic abuse report by Safe Lives** shows victims aged 61+ are much more likely to experience abuse from an adult family member or current partner than those 60 and under.

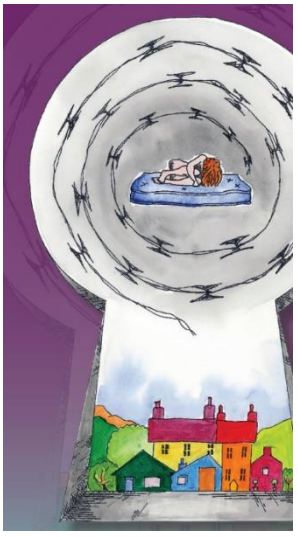
- On average, older victims experience abuse for twice as long before seeking help as those aged under 61 and nearly half have a disability.
- Somerset, like other areas around the country, sadly has had several domestic homicide reviews over the last couple of years involving older people abuse.
- Since the beginning of 2020, there have been eight deaths notified to the Safer Somerset Partnership of men and women aged 60 years and over, where domestic abuse has been a factor in their lives.
- Currently, the Safer Somerset Partnership are doing a domestic homicide review in relation to the death of a 78 -year-old man who was stabbed by his wife at their home in Somerset.
- Safe accommodation support services that meet the needs of all victims including older people is set out as a priority in the new **Somerset Domestic Abuse Strategy 2021-2024.**
- An action is identified to increase the public's and professionals' knowledge about older people and domestic abuse – that it can happen to anyone, no matter where they live, their occupation or their age.

Further information:

- Visit **http://www.somersetsurvivors.org.uk** for information on local and national services
- Call the **free confidential Somerset Domestic Abuse Helpline on 0800 69 49 999.**
- **In an emergency you should always dial 999.** If you are worried that an abuser may overhear your call you can remain silent, tap the phone and dial 55 when prompted by the operator who will send help.
- If you are deaf, hard of hearing or speech-impaired you can register with **emergencySMS.net**. Once registered you will be able to send a text to 999 if you require help in an emergency.
- **Learn more about older people and domestic abuse**

Adapted from information produced by the Safer Somerset Partnership

CQC: Restraint, segregation and seclusion review



The **Out of sight – who cares? report,** published in October 2020 by the Care Quality Commission (CQC), looked at the use of restraint, seclusion and segregation in care services for people with a mental health condition, a learning disability or autism. It highlighted the high levels of restrictive practice used in some mental health hospitals in England, and the inappropriate use of long-term segregation.

A new short report was published in December 2021 that comments on the progress following publication and highlights the main areas where further work is still needed.

Despite progress, CQC say that much still needs to be done to improve the health and care experiences of people with a learning disability and people with autism as:

- there are still too many people in inpatient hospital wards
- when admitted, some people are spending too long in hospital and discharge can be very slow
- well over 2,000 mental health inpatients were reported to have been subject to restrictive interventions in August 2021

In Spring 2022, CQC will provide a fuller update on progress against each of the 17 recommendations in *Out of sight*.

Further information

- **Read the progress report in full**
- **Blog post**
- **Easy read progress report**

Adapted from information produced by the Care Quality Commission

COVID-19 Adult Safeguarding Insight Project - Third Report

The Insight Project was developed to create a national picture regarding safeguarding adults' activity during the COVID-19 pandemic. The first report, **COVID-19 Adult Safeguarding Insight Project: Findings and Discussion**, provided a picture of how safeguarding adults activity in England was affected by the initial stage of the pandemic and first lockdown, up until June 2020. The **COVID-19 Adult Safeguarding Insight Project Second Report** provides information on safeguarding adults activity up to December 2020. This third report covers the period up to June 2021.

The third Insight Report summarises safeguarding adult's activity data and information from 106 Councils in England. Fifty councils shared qualitative insight in the third project. While some of the trends seen nationally are not reflected in our local area, the key national messages from the report include:

- Safeguarding concerns continue to show a long-term upward trend, tending to decrease during periods of lockdown and other COVID-19 restrictions. This is followed by a sharp increase once those restrictions are lifted.
- Section 42 safeguarding enquiries did not show the same upward trend shown by concerns, though they did fall and rise in line with changes in the volume of concerns.
- Due to lockdown regulations, many safeguarding concerns have been reported to adult social care services later on than before the pandemic. This has been the case for particular types of abuse, such as domestic abuse and self-neglect where lockdowns have increased the isolation of those experiencing abuse.
- The delays in reporting safeguarding concerns or related issues have altered how they have been dealt with since the pandemic. Delayed issues are less likely to be case managed, instead becoming safeguarding concerns. Delays in referral have meant that there have been more acute or severe consequences, making preventative measures more difficult to implement or situations have been more likely to require crisis management.
- The prevalence of different types of abuse has not changed considerably during the pandemic, although there is some limited evidence in the data that psychological abuse, domestic abuse and self-neglect have risen during this time. However, councils have reported increased complexity and risks in abuse types.
- The location of risk in the individual's own home has increased notably during the pandemic, despite risks located in residential and nursing care homes making up a lower percentage share of Section 42 enquiries.
- Councils reported on themes including the impact of COVID-19 on work with social care providers, increasing mental health issues, abuse of people with learning disabilities, safeguarding people who are experiencing homelessness, and carers' stress.

Further information

- **Read the full report here**

Adapted from information produced by the Local Government Association

Ann Craft Trust: Why Have Different Policies and Procedures for Safeguarding Children and Adults?

In the past, organisations have combined the safeguarding of children with the safeguarding of adults at risk from harm or abuse in both their training and in their policies and procedures.

Many organisations support both adults and children, and it may seem easier and more convenient to have a single safeguarding policy and procedures. However, this is not recommended for a number of reasons:

- Children and adults may each face a different set of issues
- The definitions and terms used differ
- Procedures for reporting abuse and handling cases are not the same
- There is different legislation and policy

Adding safeguarding adults at risk to a safeguarding children policy often dilutes the message about adults. This is particularly likely when organisations base the policy and procedures on those originally written for children.

One important difference between safeguarding adults and safeguarding children is an adult's right to self-determination. Adults may choose not to act at all to protect themselves, and it is only in extreme circumstances that the law intervenes. This will often only happen when an adult is assessed to lack capacity in that area, or where the concerns may extend to children, such as when they are living in the same household.

This can make the matter of safeguarding adults even more complex. It is not solely focused on creating an appropriate process and system to safeguard. It also needs to take into account the importance of creating a culture that embraces the adults themselves, informing and consulting them on all decisions affecting them.

Adapted from information produced by the Ann Craft Trust

Department of Health and Social Care: Adult Social Care Workforce Survey

The workforce survey was a voluntary survey completed by CQC-registered care homes and domiciliary care providers via the **capacity tracker**. It ran for a month from 13 September 2021 to 14 October 2021, with the aim of gaining insight into the scale of workforce challenges and to identify specific areas of concern.

This report documents key findings from the responses collected from almost 9,000 adult social care settings in England through the workforce survey. This represents a response rate of 27% of all Care Quality Commission (CQC)-registered care homes and 44% of all CQC-registered domiciliary care providers.

Most respondents to the survey reported an increase in challenges in the 4 key areas of recruiting staff, retaining staff, morale and accessing agency staff, over the last 6 months.

The positions reported as being hard to recruit were also reported as hard to retain. For domiciliary care providers the role most commonly reported as challenging to recruit and to retain was 'personal assistant or home care worker'. For care homes this was 'senior care worker'.

The main reason given for these shortages were that respondents felt pay and working conditions in the care sector were uncompetitive, when compared to outside sectors. Vaccination as a condition of deployment was also cited as a potential issue for care homes.

The overall situation

Respondents were asked "Compared to April 2021, how would you describe the current level of workforce challenges in your service or location for…?"

a) retaining staff
b) recruiting staff
c) maintaining staff morale
d) accessing agency staff

Table 1: responses to "Compared to April 2021, how would you describe the current level of workforce challenges in your service or location for…?"

Question	More challenging	About the same	Less challenging	Response rate (with number)
Retaining staff	70.3%	25.0%	4.5%	98% (8765)
Recruiting staff	81.9%	15.1%	2.5%	97% (8677)
Maintaining morale	70.6%	24.5%	4.4%	98% (8735)
Accessing agency staff	77.9%	16.6%	2.4%	58% (5238)

Totals may not add up to 100% as answers of 'unsure' and 'don't know' have been omitted. Full breakdowns are available in sheets 1.1, 2.1, 3.1 and 4.1 of the accompanying workforce survey data tables in the full report.

Further information:

- **Read the full report**

Adapted from information produced by the Department of Health and Social Care

Business Manager Blog


Stephen Miles SSAB Business Manager

So, Christmas has been and gone, and I know that for so many of those working over the period it was a time of huge work pressures, not the rest and relaxation that is so often portrayed in the media and I want to convey the thanks of the Board to each and every person who worked over the festive period to support the most vulnerable people in our county. The services that keep people safe, and those that provide them, may not get the publicity or recognition they deserve, but even though I've now (slightly scarily for me) spent over a quarter of a century working around adult social care services, I never cease to be humbled by those who go the extra mile for other people. For about a year up to August 2021, one of the additional roles I had was to produce the weekly Adult Social Care briefing that I know that many colleagues received, and each

week I wrote how much the work of colleagues across the system was valued, and each week I meant it. Thank you.

Christmas for me involved being cautious – as a family we got to see some people, but not some others, as a result of the omicron variant. To date we've been really lucky as while we've had periods of self-isolation, mostly when my son was defined as a close contact at school, to deal with, we've not yet had a positive test, even though at times it has felt like an inevitability with the levels locally. But I know that many others haven't been, that they are still feeling ill many months on from when they were originally ill, have lost loved ones, or feel that the last two years have been so challenging that they are struggling to cope. As a system we are therefore encouraging care staff to maintain their wellbeing and be available to each other for everyday support and friendly conversation to support a culture of openness around good mental and emotional health. In addition, there are resources available to support the local care sector during difficult times:

- **Somerset Emotional Wellbeing Staff Hub** – a dedicated online resource for all health and care workers in Somerset
- **Our Frontline -** mental health and bereavement support for care workers
- **Somerset Mindline** – open 24/7

Before Christmas we published a Safeguarding Adults Review for Matthew, which you can read more about on page 9, and which was a review that I was involved in working on during the various lock downs. While it took us longer to get to the publication stage than I would have liked, primarily because of the pandemic, I hope that the learning we have identified is helpful.

It was good to take part in the series of webinars that we organised and ran as the five Safeguarding Adults Boards within the Avon & Somerset police footprint in November. These were coordinated by colleagues in South Gloucestershire, with the recordings hosted by Bristol, so a really collaborative piece of work across the five Boards. We've also completed the self-audit process, which we coordinated, and I'm looking forward to sharing the results to the Board in February. Along with other Boards, we were also offered a chance to have a short animation, originally produced for colleagues in Norfolk, called 'Tricky Friends', adapted to show our information which we were very grateful for, and which is now available on our **website** for anyone to use when talking to people about Mate Crime. Going forwards, and in acknowledgment that there remains ongoing uncertainty over arranging in-person conferences in the way have in the past, we are planning to work as a partnership to arrange further webinars on different topics during the year for anyone working locally with adults with care and support needs to access. We hope to have arranged the first one before the end of March, which we plan to record for anyone who isn't able to view live to access. We will be circulating details for this once we have got everything set up.

Since the end of September Marion Nuttall has been working with Board, and has been brilliant at supporting its work, including writing much of this newsletter. Unfortunately for us Marion's time working with us is coming to end and she's moving on to a new role in Wales, but before she goes I want to publicly thank her for all her work and wish her the very best for her future career. We're also coming of the end of our current Strategic Plan and are beginning to formulate one for the next three years, with annual refreshes, the first draft of which will be considered by the Board when it next meets, and which we plan to offer readers of our newsletter a chance to comment on.

Learning Lessons

Local: 'Matthew' SAR (Somerset)

Background

A report was published by the Somerset Safeguarding Adults Board on 14/12/2021 and documents the events leading up to Matthew's death (pseudonym), in hospital, in January 2018.

Matthew had a history of multiple and complex health problems, including substance misuse, type two diabetes, chronic obstructive pulmonary disease (COPD) and skin infections. The day before his admission to the hospital where he died, Matthew had declined a planned admission to a community hospital and was found at home drifting in and out of consciousness by staff employed by a care agency. Matthew was admitted to the emergency department with pneumonia and type 2 respiratory failure. Hospital records state that he had been bedbound for a long period of time and had become unable to roll causing pressure damage to his skin.

Prior to his death, organisations were attempting to support Matthew in relation to his history of neglecting his own health and well-being. Matthew's case highlights the difficulties organisations face in supporting people with complex health and social care needs, who want to maintain their independence and decision making.

Findings and areas for learning and improvement

Responding to changes in need: Matthew was clearly deteriorating for several weeks leading up to his death. A short period of access to 24-hour care may have provided an opportunity to work with Matthew and could have prevented some of his early deterioration. A successful planned admission to a care home placement or a community hospital may have provided an opportunity to work more effectively with Matthew to prevent further deterioration. Neither happened. Professionals should take into consideration information that indicates that an adult's health and/or situation is on a deteriorating trajectory and respond in a timely way.

Involving other organisations: While the safeguarding response was considered to have been appropriate when referrals were made, it is unclear why concerns were not raised about Matthew's physical health much earlier in 2017. The professionals supporting Matthew were clearly concerned, but they appear to have attempted to manage the situation themselves until a critical stage was reached. Professionals should involve the other professionals and/or organisations that are/need to be involved in supporting an adult in multidisciplinary approaches and meetings in order to avoid 'firefighting' concerns in isolation.

Multi-Disciplinary Meetings: While there was a multi-disciplinary meeting in March 2017, no notes appear to have been taken and opportunities were not taken for all those involved in supporting Matthew to meet again to consider how to support him. A record must be made of all meetings, actions and who has/the organisation that has responsibility for carrying them out. This record must be shared with all the professionals/ organisations that are involved to avoid working in isolation.

Joint Working: The review identified learning that, in situations where multiple organisations are working to enable someone to be transported that requires specific logistical arrangements, this should be coordinated by a single individual/organisation, with all organisations taking ownership

and accountability for ensuring that the elements they are responsible for are delivered. There should have been agreement of a lead agency and/or professional to co-ordinate the transfer.

If plans change: When plans change, each professional/ organisation has a responsibility to inform the professional/organisation with the agreed coordination responsibility. This serves to ensure that changes to the agreed plan can be communicated to all the professionals/ organisations involved so that everyone is aware and can agree any new actions that are required. For example, in Matthew's case his decision not to be admitted to the Community Hospital when the ambulance arrived to take him, should have been communicated to all involved, who then should have reconvened to reassess the risk and agree the next plan of action.

Recording when an adult's capacity is considered: While in no way suggesting that Matthew did not have capacity at any point, at different times during the period under consideration, professionals had said that they had questioned if Matthew had the capacity to make some of the decisions that he was choosing to make. Unfortunately, the recording of information relating to this was poor. Professionals should record all occasions where an adult's capacity has been considered and why. Where there is a concern about the decisions an adult is making, consider how the underlying reasons for this can be explored with the adult and record this.

Decisions about health and care when an adult is incapacitated: Matthew had clearly expressed a view to multiple professionals that he did not wish for his family to be involved in his life or know about his health. However, on admission to hospital his family was contacted. It is unclear whether the staff who made the decision to involve Matthew's family in decisions about the ending of his treatment were aware of his wishes at the time. If an adult who has previously expressed a clear wish that their family should not be involved in decisions about their health and care becomes incapacitated, professionals should arrange for the involvement of an **Independent Mental Capacity Advocate** (IMCA) in relation to this decision.

Further information

- **Read the review**
- **Read the one-page briefing**
- **Read the press release**

Local: Domestic Homicide Reviews (DHR's)

'David' (Somerset)

David (pseudonym) was around 30 years old, from a BME background and lived with his partner and children. The review was commissioned as while David died as a result of suicide, there had been a history of domestic abuse in his relationship.

The review panel was challenged to fully understand the nature of the relationship between David and his partner as they often sought to remain private when engaging with agencies in Somerset. The review panel members noted there were times when agencies had opportunities to demonstrate more respectful uncertainty or professional curiosity, when seeking to understand any challenges or issues the family faced.

Safer Somerset Partnership
Feel Safe, Be Safe

Key considerations for practice identified in the review

Professionals to understand the impact of domestic abuse on mental health: David didn't have a mental health diagnosis, but we know that domestic abuse affects people's mental health and can

lead to suicidal thoughts. Professionals should complete Mental Health training (e.g. ASIST or MHFA), to improve support to people vulnerable to suicide.

Professionals to be "curious": Professionals should consider the full facts, and not only respond to the client's presenting issue. Professionals should also be aware of coercive control and minimising behaviour of victims or perpetrators.

Understanding barriers to disclosure by male and/or BME victims: Professionals to be aware that men and BME victims (of any gender) are often even more reluctant to or feel more unable to seek help. Specialist training may be required to improve knowledge.

Understanding referral pathways: Professionals to follow their agency's child safeguarding policies where children are known to be experiencing domestic abuse in their home. Professionals to use the domestic abuse pathways when they identify a victim.

Professionals to complete DASH risk assessments even when domestic abuse may appear "low level": By completing DASH assessments every time a disclosure is made, or a professional is aware of a new incident of domestic abuse, escalation of risk can be observed over time.

Professionals to record domestic abuse disclosures: Together with completing a DASH, professionals must fully and clearly record in their files when conversations about domestic abuse have taken place.

Professionals to share information with victims on services available to help, and make referrals when appropriate: If you identify that a client would benefit from another service, either provide them with information or make a referral to the service (with consent, unless safeguarding risk overrides this).

Further information

- **Read the Review (DHR 021)**

'William' DHR (Somerset and Dorset)

Background

In March 2019, Justin (pseudonym) subjected his 70-year-old mother Dorothy (pseudonym), who was very vulnerable as a result of her complex physical and mental health needs, to a very serious assault in the flat in which they lived together.

Prevented from contacting his mother or returning to her flat by Court imposed bail conditions, Justin eventually moved in with his father William (pseudonym), which necessitated a move from Somerset, where Justin had lived with his mother, to Dorset, where his elderly father lived alone. Two months later, Justin murdered William in May 2019.

This case was complex, with Justin's mother and father both having care and support needs and Justin's history of criminal activity and violence. There was evidence that Dorothy suffered from domestic violence and abuse from her son over a number of years. Justin was also recorded as having a 'severe functional disability' and mental health needs himself. That William was not perceived to be at risk of domestic violence and abuse from his son was the key area of learning from this review.

Findings and areas for learning and improvement

Awareness of Familial Domestic Violence and Abuse (Professionals): William's vulnerability to domestic violence and abuse appears to have been overlooked by the agencies in Somerset which

became aware of Justin's move to stay with him. No services in either Somerset or Dorset explicitly recognised William as a potential victim of domestic violence and abuse. In Somerset there had been a very strong focus on safeguarding Dorothy from domestic violence and abuse. William appears to have been viewed completely differently, possibly because he was male and, until his recent prostate cancer diagnosis had been in very good physical health. In the absence of any reported history of violence between them, he may have been seen as being capable of handling his son. William's age at the time of his murder (73) may have been another factor which obscured the risks of domestic abuse he faced. Professional awareness should be raised of the dynamics of familial domestic abuse and the need to apply what has been learnt about intimate partner domestic abuse, whilst recognising that there are important differences between intimate partner and familial domestic abuse. Agencies involved in safety planning for the victims of domestic violence and abuse should take a 'Think Family' approach, to ensure that other family members who may also be at risk of domestic abuse are not overlooked.

The extent to which opportunities to uncover domestic violence and abuse are adversely affected by narrow, reactive task-focused approach of services: It seems probable that Dorothy was not asked about domestic abuse because she was not known to be in an intimate relationship. Overall, the focus of Adult Social Care only on the presenting problem seems unlikely to have provided opportunities to unearth the presence of familial domestic abuse, assuming that in this case, Dorothy was prepared to disclose any earlier abuse against her. Professional curiosity must be shown to identify familial domestic abuse in the same way that it must be for domestic abuse experienced within intimate partner relationships.

Information sharing where a person who presents risks to others moves from one geographic area to another: There were missed opportunities for information held by agencies in Somerset to be shared with agencies in Dorset. As Dorothy's case was not discussed at MARAC, it was not possible for the local Somerset MARAC to consider any risks associated with Justin's move to stay with his father in Dorset. SafeLives guidance on MARAC-to-MARAC referrals states that they should be made when partner agencies become aware that a victim has moved between areas, either on a temporary or permanent basis. In this case it was the perpetrator who had moved.

Inclusiveness of safety planning for victims: The Deane Helpline played an important role in safeguarding Dorothy (alerting the police to the March 2019 assault) but this role may not have been fully recognised and exploited by partner agencies. Had they been involved in the safety planning they may have more fully appreciated the seriousness of the first potential breach of bail conditions by Justin and contacted the police via 999 as opposed to 101. All partner agencies which could have a role to play in safety planning for victims of domestic violence and abuse should be involved in safety planning.

Further information

- **Read the Review (DHR 026)**

You can read other DHRs and case summaries published by the Safer Somerset Partnership **here**
and DHRs published by Dorset Community Safety Partnership **here**

National

'Katherine' SAR (Dorset)

Background:

In 2019, Katherine (pseudonym), a 85-year-old woman, was admitted to hospital following a reported assault by her husband. She later died.

In her later years, Katherine experienced a number of physical health issues. She initially accessed support from services in respect of her role as carer for her husband but later for her own care and support needs. Both her caring responsibilities and health issues increased towards the end of her life. She was married for over 60 years and both she and her husband held strong religious beliefs. These beliefs guided and informed her decision making throughout her life.

Key considerations for practice identified in the review

Enabling practitioners in all agencies to have a role in 'sowing the seeds' with an older domestic abuse victim to do something about the abuse: The disincentives for older people who have been living with domestic abuse over years, to do something about it, are many. These include attitudes and beliefs particularly around gender roles, financial dependency on their abuser, or preconceptions about their partner's inability to manage, due to illness and dependency, without their care. The report highlights the importance of consistent dialogue about an older victim's experiences and persistent encouragement to accept help.

Recognising coercive and controlling behaviour in old aged married men: In general, in older age people's worlds start to shrink, opportunities to leave the house and to see other people reduce, physical illnesses progress, depression and anxiety often rise, and the complex interdependency of caring roles are layered over earlier relationship dynamics and behaviour patterns. What surfaced through the SAR is the potential for professionals either to deny the possibility of abusive behaviours and/or to minimise their impact on the victim, due to a benign, if infantilising, view of men in older age.

Availability of specialist domestic abuse expertise for practitioners working with victims of domestic abuse who decline specialist Domestic Abuse services and where domestic abuse is on-going: Specialist domestic abuse services will often be declined, even though the domestic abuse continues. A safe system therefore cannot rely only on domestic abuse expertise coming directly through specialist domestic abuse service staff. There is also a need to provide domestic abuse expertise indirectly to professionals engaging with an older victim in other roles. This could be located with safeguarding or be an expansion of a domestic abuse service. It would have the additional benefit of building on positive relationships that already exist between the older victim and particular professionals.

Enabling confidence across agencies about engaging with men about their abusive behaviours: A key part of tackling domestic abuse is engaging with perpetrators about their behaviours. This needs to be underpinned by a risk assessment due to the possibilities of escalating the person's abusive behaviour. These conversations can be led by anyone who has a relationship with the person concerned, dependent on the practitioner's skill and confidence.

Engaging with faith groups as important safeguarding partners: Faith leaders, staff or volunteers of faith organisations and community members can play an important role in ensuring that faith is a resource rather than a roadblock for people subject to domestic violence. Faith leaders and

community members can assist people in abusive domestic relationships as well as working to hold perpetrators accountable. Faith groups therefore are important safeguarding partners. It is of course vital they have a good understanding of domestic violence to avoid inadvertently escalating situations and increasing risks.

Further information

- **Read the report**
- **Safeguarding for faith groups**
- **Free intervention programme for male perpetrators**

Learning from the Somerset Safeguarding Children Partnership

We encourage our readers to have a look at the latest Learning Bulletin from the Somerset Safeguarding Children Partnership**, 'Things You Should Know',** which in their December edition includes information about their new guidance on 'Effective Support for Children and Families in Somerset' and learning from a recent case in which services worked together to safeguard a toddler living with a mother experiencing domestic abuse.

Local & National News and Headlines

- BBC NEWS: **Calls to male sexual abuse helpline double in 2021** (January 2022)
- The Guardian: **More than 90 care home operators in England declare red alert over staffing** (January 2022)
- BBC NEWS: **Covid: Vulnerable NHS patients to be offered new drug** (December 2021)
- Community Care: **Covid delays in adult safeguarding have led to 'severe consequences' for people needing services** (December 2021)
- Local Government Association: **LGA responds to adult social care reform white paper** (December 2021)
- BBC NEWS: **Tony Hickmott: Autistic man was 'loneliest man in the hospital'** (December 2021)
- Community Care: **Liberty Protection Safeguards consultation 'to launch early 2022', but new target date unlikely** (December 2021)
- Department of Health and Social Care (Policy Paper): **People at the Heart of Care: adult social care reform** (December 2021)
- Hourglass (Report): **Safer ageing index part 1: Research** (December 2021)
- National Institute for Health Research: **A highly personalised approach to end-of-life care is needed to help Gypsy, Traveller and Roma communities** (December 2021)
- Home Office (Report): **2021 UK annual report on modern slavery** (November 2021)
- The Charity Commission (Guidance): **Safeguarding for charities and trustees** (November 2021)
- Healthwatch Somerset: **Healthwatch recommends improved communication and support for patients waiting for surgery in Somerset** (November 2021)
- National Institute for Health Research: **Care home staff saw long-term benefits from an intervention to help people with dementia** (November 2021)

- National Institute for Health and Care Excellence: **NICE calls for healthcare professionals to use shared decision making best practice to highlight the risks of medicines associated with dependence** (October 2021)

Training and Development

It is the responsibility of all organisations to ensure they have a skilled and competent workforce who are able to take on the roles and responsibilities required to protect adults at risk and ensure an appropriate response when adult abuse or neglect does occur. The SSAB does not provide any single or multi-agency training but has published a **Somerset Adult Safeguarding Learning Framework**.

Somerset Survivors: e-Learning (free)

- **Professional e-Learning modules on domestic abuse**
- **Domestic Abuse and Modern Slavery e-Learning modules for the public**

Social Care Institute for Excellence: e-learning (please note that SCIE are now charging for this content)

- **e-learning: Adult Safeguarding Resource**
- **e-learning: Mental Capacity Act**

Other resources

- **FutureLearn Safeguarding Adults Level 3 Training**
- **Friends Against Scams Practitioner E-Learning**
- **Health Education England e-Learning Mental Capacity Act e-Learning**
- **Unseen Modern Slavery training**
- **Home Office Prevent e-learning**
- **Home Office FGM (Female Genital Mutilation) e-learning**

Real Safeguarding Stories is a learning tool dedicated to raising awareness of safeguarding issues. By telling compelling stories based upon real life events, it helps professionals understand these complex issues. Understanding and relating to these stories is the first step towards individuals and organisations being better able to support those at risk. On this website you will find a series of videos, each exploring different aspects of safeguarding – including child and adult safeguarding, and domestic abuse. These are based on the experiences of professionals working in the field and from interviews with victims of abuse. The videos are then scripted and filmed using actors in a realistic context, with each video supported by guidance to support wider training or awareness activity. Visit: **http://realsafeguardingstories.com/**

SSAB Board Meetings

At its meeting in October 2019, the Board made a decision to publish the minutes of Board meetings in full from that meeting onwards, with the exception of redacting confidential information relating to an individual (for example where someone has spoken about their experience of being safeguarded). Notes are published on the **SSAB Website** retrospectively following sign-off at the next meeting.

Useful Safeguarding Adults Links:

- **Secure professionals e-referral form**
- **Joint Safeguarding Adults Policy**
- **Somerset Adult Safeguarding Guidance**
- **Practice guidance and resources**
- **Get the SSAB Website on your phone or tablet**
- **National Safeguarding Adults Review (SAR) Library**

Get in touch

If you have any suggestions for future topics or comments about this newsletter, please contact us via:

ssab@somerset.gov.uk

Alternatively call our Business Manager, Stephen Miles, on:
01823 359157

If you are worried about a vulnerable adult, don't stay silent

Phone: **0300 123 2224**
Email: **adults@somerset.gov.uk**

Or complete a secure
Professionals e-referral form

In an emergency always contact the police by dialling 999.
If it is not an emergency, dial 101

SOMERSET SAFEGUARDING ADULTS BOARD